TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ENNIS ORTHOPEDICS, PA

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-17-2908-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JUNE 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position Summary was not submitted with dispute packet.

Amount in Dispute: $75.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider was paid for CPT 20610…and therefore the visit is included in the global period of CPT 20610."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2017	CPT Code 99212-25-57 Office Visit	$75.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20, effective January 29, 2009 sets out the health care providers billing procedures.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97, X212, W3-This procedure is included in another procedure performed on this date.

Issues

1. What is the applicable fee guideline?

2. Is the allowance of code 99212 included in the allowance of code 20610?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   On the disputed date of service the requestor billed CPT codes 99212-25-57, 20610-LT and J1040. These codes are described as:

   99212: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

   Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service was added to code 99212.

   Modifier 57: Decision for Surgery was added to code 99212.

   20610: Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance.

   Modifier LT: Left side was added to code 20610.

   J1040: Injection, methylprednisolone acetate, 80 mg.

   The insurance carrier denied reimbursement for the office visit , CPT code 99212, based upon reason code "97-, X212, W3-This procedure is included in another procedure performed on this date". The respondent contends that reimbursement is not due because "If a procedure has a global period of 000-or 010 days, it is defined as a minor surgical procedure. E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service. Global period for code 20610 is 000 days; therefore, based on correct coding rules, and Evaluation and Management Code should have been included."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Per Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(1), Billing Requirements for Global Surgery:

   To ensure the proper identification of services that are, or are not, included in the global package, the following procedures apply.

   A. Procedure Codes and Modifiers

   Use of the modifiers in this section apply to both major procedures with a 90-day postoperative period and minor procedures with a 10-day postoperative period (and/or a zero day postoperative period in the case of modifiers "-22" and "-25").

   1. Physicians Who Furnish the Entire Global Surgical Package

Physicians who perform the surgery and furnish all of the usual pre-and postoperative work bill for the global package by entering the appropriate CPT code for the surgical procedure only. Billing is not allowed for visits or other services that are included in the global package.

The issue in dispute is whether or not the February 21, 2017 office visit (CPT code 99212) is included in the global surgery package of CPT code 20610 rendered on the same day.

A review of the submitted documentation finds that the requestor performed the surgery and office visit. Therefore, the Division finds that the Medicare policy on global fee surgical package applies to the service in dispute.

Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(4), Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery:

Evaluation and management services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.
In addition to the CPT evaluation and management code, modifier "-57" (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery. (Modifier "-QI" was used for dates of service prior to January 1, 1994.)
If evaluation and management services occur on the day of surgery, the physician bills using modifier "-57," not "-25." The "-57" modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.

A review of the submitted medical billing finds that the requestor appended modifiers 25 and 57 to CPT code 99212 to indicate that the service was unrelated to code 20610.

The Division finds that reimbursement is not due based upon the following:

- Code 20610 is classified as a minor surgery because it has a 0 day postoperative period.
- The requestor did not support billing with modifier 25 because the report does not support a separate evaluation and management service in conjunction with code 20610.
- Per Medicare Claims Processing Manual Chapter 12, (40.2)(A)(4), modifier 57 is not used with minor surgeries.
- Per Medicare Claims Processing Manual Chapter 12, (40.2)(A)(4)," the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure."

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/13/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.